

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-029783

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

318
1003
7677
FILED AUG 1 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
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2 4006						
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4 1						
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12 8-0						
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58						
USE BLACK INK OR TYPEWRITER RIBBON	SHOULD READ					
ITEM NO.						

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN University City	
Length of stay in 1b 4 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If outside, give location) 7342 Carleton Ave.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Maud Miller Chasey		4. DATE OF DEATH Month Day Year July 25, 1963	
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-22-1880
9. AGE (last birthday) 83		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (City and state or country) Brooklyn, N.Y.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Leander Chasey		13b. MOTHER'S MAIDEN NAME Martha Ryder	
14. NAME OF HUSBAND OR WIFE C. Austin Chasey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Russell Nash, 7342 Carleton Ave. (30)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterio-Sclerotic Heart Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arterio-Sclerosis DUE TO (c) 4200		INTERVAL BETWEEN ONSET AND DEATH Long Standing	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from July 21, 1963 to July 25, 1963 and last saw her alive on 7/25/63 Death occurred at 3:00 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) George F. Rendleman, M.D.		22b. ADDRESS 812 Olive Street St. Louis, Mo.	
22c. DATE SIGNED 7/26/63		22d. LOCATION (City, town, or county) (State) St. Louis County	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 7-29-63	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	
24. FUNERAL DIRECTOR Alexander & Sons, 6175 Delmar Blvd.	25. DATE RECD. BY LOCAL REG. JUL 26 1963	26. REGISTRAR'S SIGNATURE Road Smith, M.D.	

(Licensed Embalmer's Statement on Reverse Side)

Dr. George F. Rendleman
812 Olive

Office hours: After 1:00 P.M.

Phone: CH 1-9261

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. Allen Davis

Licensed Embalmer No. 4053

P. O. Address H. L.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.